TINJAUAN PENETAPAN KODE EXTERNAL CAUSE KASUS KECELAKAAN PADA DOKUMEN REKAM MEDIS RAWAT INAP DI RUMAH SAKIT PERMATA MEDIKA SEMARANG TRIWULAN I TAHUN 2017

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ABSTRAK

ICD-10 adalah acuan dalam mengkode penyakit. Berdasarkan survei awal pada 10 DRM, 20% DRM menyertakan kode cedera tetapi tidak menyertakan kode external cause, sedangkan 80%DRM menyertakan kode cedera dan kode external cause, tetapi kode external cause tersebut tidak terisi sampai karakter keempat dan kelima.Penelitian ini bertujuan untuk menjelaskan informasi tentang kasus kecelakaan pada DRM kasus external cause, menjelaskan diagnosa utama dan kode diagnose utama external cause. Penelitian deskriptif dilakukan dengan metode observasi. Populasi pada penelitian ini yaitu DRM rawat inap pada triwulan I tahun 2017 sebanyak 21 DRM. Penelitian ini menggunakan ceklist penetapan kode external cause. Berdasarkan hasil penelitian terhadap 21 dokumen rekam medis, 61,9% dokumen rekam medis tidak lengkap, diagnosa tidak tertulis pada seluruh dokumen rekam medis (100%), 14,30% dokumen rekam medis telah dikoding tetapi kode tidak spesifik. Saran, RS sebaiknya memberi pelatihan koding, petugas sebaiknya lebih memperhatikan tiap lembar rekam medis, Petugas jaga lebih teliti dalam memeriksa rekam medis, Dokter wajib menulis diagnosa serta informasi yang lengkap pada rekam medis.

Kata Kunci : Kode external cause,ICD-10, Dokumen rekam medis

REVIEW DETERMINATION OF EXTERNAL CAUSE CODE ACCIDENT CASES ON INPATIENT MEDICAL RECORDS AT PERMATA MEDIKA HOSPITAL SEMARANG 1ST QUARTER 2017

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ABSTRACT

ICD-10 was a reference in coding disease. Based on a preliminary survey of 10 medical records, 20% medical records included injury codes but had not include external cause codes, while 80% of medical records included injury codes and external cause codes, but the external cause code was not filled until the fourth and fifth characters. This study aimed to explained information about the accident case in external cause case medical records, explained the main diagnosis and external cause diagnosis code. Descriptive study was done by observation method. The population study was inpatient medical records at 1st quarter 2017 as much as 21 medical records. This study used an external cause code checklists. Based on results in 21 medical records, 61.9% of medical records were not complete, diagnosis was not written on all medical records (100%), 14.30% medical records had been coded but the code were not specific. Recommendation, hospitals should provide coding training, officers should pay more attention on every sheets of medical record, Guard officers should be more accurate in checking medical records, Doctors must write a diagnosis and complete information on medical records.

Keyword : external cause code, ICD-10, Medical records